

STATE OF ILLINOIS

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Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/03Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>93</u>	Skilled Pediatric (SNF/PED)	<u>93</u>	<u>34,038</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>34,038</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>29,599</u>	<u>397</u>	<u>19</u>	<u>30,015</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>29,599</u>	<u>397</u>	<u>19</u>	<u>30,015</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.18%

D. How many bed-hold days during this year were paid by Public Aid?

525 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/15/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 8/15/89NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0

and days of care provided

N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 6/30/04Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/03

Ending:

6/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	168,280	31,954	7,965	208,199		208,199	(74,824)	133,375		1
2	Food Purchase		154,890		154,890		154,890		154,890		2
3	Housekeeping	157,311	15,739	1,574	174,624		174,624		174,624		3
4	Laundry	73,430	16,595		90,025		90,025		90,025		4
5	Heat and Other Utilities			61,125	61,125		61,125		61,125		5
6	Maintenance	51,734	5,736	22,224	79,694	473	80,167		80,167		6
7	Other (specify):*										7
8	TOTAL General Services	450,755	224,914	92,888	768,557	473	769,030	(74,824)	694,206		8
	B. Health Care and Programs										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	2,218,360	105,502	16,653	2,340,515	44	2,340,559		2,340,559		10
10a	Therapy	63,339		40,680	104,019		104,019		104,019		10a
11	Activities	95,574	967		96,541		96,541		96,541		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation		1,824	2,350	4,174	(717)	3,457	(79)	3,378		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,377,273	108,293	70,183	2,555,749	(673)	2,555,076	(79)	2,554,997		16
	C. General Administration										
17	Administrative	100,131		147,963	248,094	(146,947)	101,147	(1,016)	100,131		17
18	Directors Fees					8,128	8,128		8,128		18
19	Professional Services			409,350	409,350	45,615	454,965		454,965		19
20	Dues, Fees, Subscriptions & Promotions			17,185	17,185	166	17,351		17,351		20
21	Clerical & General Office Expenses	70,649	12,779	11,954	95,382	32,358	127,740	(297)	127,443		21
22	Employee Benefits & Payroll Taxes			744,926	744,926	5,138	750,064		750,064		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,630	12,630	2,628	15,258	(1,830)	13,428		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,423	37,423		37,423		37,423		26
27	Other (specify):* Bad Debt			(1,000)	(1,000)		(1,000)	1,000			27
28	TOTAL General Administration	170,780	12,779	1,380,431	1,563,990	(52,914)	1,511,076	(2,143)	1,508,933		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,998,808	345,986	1,543,502	4,888,296	(53,114)	4,835,182	(77,046)	4,758,136		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Walter Lawson Children's Home

#0035469

Report Period Beginning:

7/1/03

Ending:

6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			129,086	129,086	23	129,109		129,109			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			403,216	403,216	53,564	456,780	(26,753)	430,027			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,125	13,125	(473)	12,652	(1,637)	11,015			35
36	Other (specify):* Amortization			23,846	23,846		23,846	(13,684)	10,162			36
37	TOTAL Ownership			569,273	569,273	53,114	622,387	(42,074)	580,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,432	321,432		321,432		321,432			42
43	Other (specify):* Edu/Day Training	850,407	6,854	32,425	889,686		889,686		889,686			43
44	TOTAL Special Cost Centers	850,407	6,854	353,857	1,211,118		1,211,118		1,211,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,849,215	352,840	2,466,632	6,668,687		6,668,687	(119,120)	6,549,567			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/03Ending: 6/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(26,753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,000	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(297)	21		28
29	Other-Attach Schedule	(92,054)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,104)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,016)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,016)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (119,120)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Walter Lawson Children's Home

ID# 0035469

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Scholl Lunch Reimbursement	\$ (74,824)	1	1
2	Amortization - Goodwill	(13,684)	36	2
3	Personal Use of Vehicle	(1,277)	35	3
4	Personal Use of Vehicle	(79)	14	4
5	Non-Allowable Travel	(810)	24	5
6	Non-Allowable Out-of-State Travel	(1,020)	24	6
7	Rent Equipment	(360)	35	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(92,054)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Walter Lawson Children's Home

0035469

Report Period Beginning:

7/1/03

Ending:

6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(74,824)	0	0	0	0	0	0	0	0	0	0	(74,824)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(74,824)	0	0	0	0	0	0	0	0	0	0	(74,824)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(79)	0	0	0	0	0	0	0	0	0	0	(79)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(79)	0	0	0	0	0	0	0	0	0	0	(79)	16
	C. General Administration													
17	Administrative	0	(1,016)	0	0	0	0	0	0	0	0	0	(1,016)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(297)	0	0	0	0	0	0	0	0	0	0	(297)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,830)	0	0	0	0	0	0	0	0	0	0	(1,830)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	1,000	0	0	0	0	0	0	0	0	0	0	1,000	27
28	TOTAL General Administration	(1,127)	(1,016)	0	0	0	0	0	0	0	0	0	(2,143)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,030)	(1,016)	0	0	0	0	0	0	0	0	0	(77,046)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

7/1/03

Ending:

6/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Exceptional Care & Training Center	Sterling			
		Swann Special Care Center	Champaign			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland Bean-Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expense	\$ 147,963	Hoosier Care, Inc.	100.00%	\$ 146,947	\$ (1,016)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 147,963			\$ 146,947	\$ * (1,016)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Walter Lawson Children's Home # 0035469 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,891			Director Fees	\$ 1,626	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,891			Director Fees	1,626	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,891			Director Fees	1,626	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,891			Director Fees	1,625	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,891			Director Fees	1,625	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,128		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

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Ending:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Hoosier Care, Inc.

Street Address

535 West Second, Suite 105

City / State / Zip Code

Lexington, KY 40508

Phone Number

(859) 255-0075

Fax Number

(859) 281-5150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10 Nursing / Medical Records	Revenue	40,575,961	8	\$ 255	\$ 0	6,931,272	\$ 44	1
2	18 Director's Fees	Revenue	40,575,961	8	47,583	0	6,931,272	8,128	2
3	19 Professional Fees	Revenue	40,575,961	8	267,033	0	6,931,272	45,615	3
4	20 Fees, Subscription & Promotion	Revenue	40,575,961	8	969	0	6,931,272	166	4
5	21 Clerical & General Office Exp.	Revenue	40,575,961	8	189,427	0	6,931,272	32,358	5
6	22 Emp. Benefits & Payroll Tax	Revenue	40,575,961	8	30,076	0	6,931,272	5,138	6
7	24 Travel & Seminar	Revenue	40,575,961	8	11,189	0	6,931,272	1,911	7
8	30 Depreciation	Revenue	40,575,961	8	136	0	6,931,272	23	8
9	32 Interest Expense	Revenue	40,575,961	8	313,568	0	6,931,272	53,564	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 860,236	\$		\$ 146,947	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	City of Loves Park - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 5,500,000	\$ 5,285,000	6/1/2034	7.1250	\$ 379,110	1	
2	City of Loves Park - 1999B		X	Purchase of Facility	Varies	7/8/99	250,000	225,000	6/1/2019	10.5000	24,106	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Allocation										53,564	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,750,000	\$ 5,510,000			\$ 456,780	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,750,000	\$ 5,510,000			\$ 456,780	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Walter Lawson Children's Home**# **0035469**

Report Period Beginning:

7/1/03

Ending:

6/30/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	None	8		
	2000		9		
	2001		10		
	2002		11		
	2003		12		
Note: The facility became exempt from property taxes starting 1/1/96.					
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walter Lawson Children's Home COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0035469

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 21,182

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>SNF/PED</u>	<u>217,364</u>	<u>1989</u>	<u>\$ 665,000</u>	<u>1</u>
2			<u>1997</u>	<u>19,428</u>	<u>2</u>
3	TOTALS	217,364		\$ 684,428	3

Facility Name & ID Number Walter Lawson Children's Home# 0035469

Report Period Beginning:

7/1/03

Ending:

6/30/04**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1989	1971	\$ 2,917,000	\$ 63,425	10-40	\$ 63,425		\$ 1,326,089	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roofing		1989		1,625		5			1,625	9
10	Carpeting		1990		936		3			936	10
11	Heater / A-C		1990		17,400		5			17,400	11
12	Improvements		1991		1,563		10			1,563	12
13	Water Heater		1991		961		10			961	13
14	Door Frame Molding		1991		527		10			527	14
15	Doors		1991		738		10			738	15
16	Water Heater		1992		1,749		10			1,749	16
17	Handrails		1992		584		10			584	17
18	Roofing		1992		2,258		10			2,258	18
19	Water Line		1992		755		10			755	19
20	Smoke Dampers		1993		2,400		10			2,400	20
21	Blacktop Driveway		1993		10,130	337	10	337		10,130	21
22	Install Duct Runs		1994		750	38	10	38		750	22
23	Remodel Laundry Room		1994		3,154	184	10	184		3,154	23
24	Weather-Stripping Replacement		1994		1,849	108	10	108		1,849	24
25	Remodel Laundry Room		1994		2,063	138	10	138		2,063	25
26	A/C Roof Top Unit		1994		8,985	898	10	898		8,985	26
27	Install Sump Pump and Man Hole		1994		3,200	320	10	320		3,120	27
28	Anti-Scald Valve		1995		696	70	10	70		653	28
29	Alarm Ansul System		1995		1,253	125	10	125		1,167	29
30	Garbage Disposal		1995		1,067	107	10	107		972	30
31	Water Booster System Replacement		1995		6,941	694	10	694		6,593	31
32	Carpet for Offices		1995		2,432	243	10	243		2,262	32
33	Strip/Seal North Parking Lot		1995		3,382	338	10	338		2,986	33
34	Additional Parking Spaces		1995		2,375	237	10	237		2,074	34
35	Replace Gutters & Down Spouts		1995		2,150	215	10	215		1,917	35
36	Install New Windows		1995		2,588	258	10	258		2,215	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Gazebo Building	1995	\$ 1,676	\$ 168	10	\$ 168	\$	\$ 1,442		37
38	Tile Kitchen Floor	1996	5,187	519	10	519		4,411		38
39	Bi-Fold Mirror Doors	1996	699	70	10	70		589		39
40	Clear Theralite Window Panel	1996	730	73	10	73		614		40
41	Remodel Kitchen - Ceiling Tiles	1996	279	28	10	28		233		41
42	Install Water Heater	1996	4,981	498	10	498		4,150		42
43	Install Hatco Water Heater	1996	1,550	155	10	155		1,292		43
44	New Roof on West Entrance	1996	1,150	115	10	115		949		44
45	Install New Mixing Valve	1996	2,960	296	10	296		2,442		45
46	Service Sink	1996	644	64	10	64		507		46
47	Vinyl Replacement Windows	1996	1,725	173	10	173		1,340		47
48	Install Water Heater	1997	6,014	601	10	601		4,458		48
49	Shower Trolley	1997	10,924	1,092	10	1,092		8,008		49
50	Stonebridge Tile-Bathing Area	1997	666	67	10	67		491		50
51	Drain, Lines, Vent Shower Trolley	1997	1,340	134	10	134		983		51
52	Install 175 Watt Fixture	1997	1,427	143	10	143		1,049		52
53	Replace Temperature Control Board - A/C	1997	1,021	102	10	102		740		53
54	Water Circulation Pump	1997	675	68	10	68		482		54
55	Re-Roof North Wing, Gravel Roof	1997	27,597	2,760	10	2,760		19,549		55
56	Parking Lot	1997	9,898	990	10	990		6,765		56
57	Fence	1997	5,680	568	10	568		3,834		57
58	Dirt & Sod	1997	1,075	108	10	108		720		58
59	Reinstall AC Roof Top Unit	1997	2,975	297	10	297		2,079		59
60	Security System	1997	2,362	236	10	236		1,632		60
61	Hopper Service Sink	1997	660	66	10	66		451		61
62	Install Frame/Door	1997	1,135	57	20	57		380		62
63	Education Wing	1997	137,582	6,879	20	6,879		45,860		63
64	Contractor's Fee - Education Wing	1997	73,788	3,689	20	3,689		24,594		64
65	V.C. Tile	1997	610	31	20	31		206		65
66	Contractor's Fee - Education Wing	1997	40,125	2,006	20	2,006		13,374		66
67	Install Fire Alarm Panel	1997	700	35	20	35		233		67
68	Ductwork On Roof	1997	538	27	20	27		180		68
69	Re-locate Roof Top Unit	1998	4,712	236	20	236		1,573		69
70	TOTAL (lines 4 thru 69)		\$ 3,354,596	\$ 90,086		\$ 90,086	\$	\$ 1,564,085		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,354,596	\$ 90,086		\$ 90,086		\$ 1,564,085	1
2	Grade & Sod	1998	520	52	10	52		347	2
3	Contractor's Fee - Education Wing	1998	26,724	1,336	20	1,336		8,907	3
4	Replace Blower Motor	1998	620	62	10	62		408	4
5	Pour New Concrete	1998	945	95	10	95		617	5
6	Install Emergency Generator	1998	85,328	8,533	10	8,533		55,464	6
7	Cabinets & Countertops	1998	788	79	10	79		513	7
8	Replace Inducer Motor	1998	837	84	10	84		539	8
9	Replace Heat Exchanger, Burners & Deflection Plate	1998	1,228	123	10	123		779	9
10	Install New Receptacle, Box & Separated Circuits	1998	1,639	164	10	164		1,039	10
11	Roof	1998	700	70	10	70		437	11
12	Install Thermalite Window	1998	570	57	10	57		352	12
13	Blacktop New Parking Lot and Driveway	1998	9,752	975	10	975		5,850	13
14	Install New Aluminum Siding/Install New Gutter	1998	1,397	140	10	140		840	14
15	Replace Gas Valve, Thermostats, Circuit Board, Ignitor	1998	1,008	101	10	101		581	15
16	Install New Roof-Top Heating / Air Conditioning Unit	1999	4,340	434	10	434		2,387	16
17	Re-Tile Bathtub Room Floor and Walls	1999	2,080	208	10	208		1,144	17
18	New Bathtub, Install Drain, Vent, Water Lines	1999	1,780	178	10	178		964	18
19	Install New Sink	1999	676	68	10	68		379	19
20	Heat Exchanger	1999	912	91	10	91		485	20
21	Roof-Top Unit Replace Motor	1999	731	73	10	73		376	21
22	Tear Off and Replace Roof	1999	2,500	125	20	125		625	22
23	Install New Roof Shingles, Facia Boards & Vents	1999	3,727	186	20	186		868	23
24	Furnish and Install True 2-Door Freezer	1999	3,265	218	15	218		1,017	24
25	Install New Heat Exchanger	2000	730	49	15	49		220	25
26	Extension and Enlargement of Sewer System Pipes	2000	1,804	120	15	120		540	26
27	Installed New 50 Gallon Water Heater	2000	918	61	15	61		264	27
28	New Toshiba Strata Digital Telephone System	2000	3,264	326	10	326		1,413	28
29	New Toshiba Strata Digital Telephone System	2000	6,528	653	10	653		2,830	29
30	New Toshiba Strata Digital Telephone System	2000	1,478	148	10	148		641	30
31	Tear Off and Replace North Flat Roof	2000	1,147	57	20	57		238	31
32	Replace Concrete at Pavillion	2000	2,700	180	15	180		690	32
33	Cement Walk & Landscaping to Prevent Flooding	2000	900	60	15	60		225	33
34	TOTAL (lines 1 thru 33)		\$ 3,526,132	\$ 105,192		\$ 105,192		\$ 1,656,064	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,526,132	\$ 105,192		\$ 105,192		\$ 1,656,064		1
2	Seal and Stripe Parking Lot	2000 1,600	160	10	160		600		2
3	Install Two RPZ Backflow Preventor	2000 2,445	163	15	163		625		3
4	Fire Sprinkler System Installation	2001 37,774	1,511	25	1,511		5,288		4
5	New Laundry Room Air Intake Filter	2001 623	25	25	25		81		5
6	Sprinkler System Valve	2001 2,200	88	25	88		279		6
7	Duro-Last Roof System Installation	2001 40,846	1,634	25	1,634		5,174		7
8	Trolly Shower Mattress	2001 900	90	10	90		270		8
9	New Door	2001 2,085	139	15	139		405		9
10	Booster Pump	2001 4,838	322	15	322		832		10
11	Cornice	2001 859	57	15	57		162		11
12	Nurse's Station	2001 6,594	440	15	440		1,210		12
13	Foyer Carpet	2001 2,341	234	10	234		644		13
14	Internet Wiring	2002 2,341	156	15	156		377		14
15	Install Steel Door Frame	2002 1,485	99	15	99		182		15
16	New Heat Exchanger	2002 2,818	188	15	188		345		16
17	Gutters & Downspouts	2002 900	90	10	90		165		17
18	Internal Parts Tempering	2002 1,356	136	10	136		238		18
19	Classroom Tile	2002 500	50	10	50		83		19
20	Heat Exchanger	2002 1,106	74	15	74		111		20
21	Remodeling Project	2003 3,541	354	10	354		384		21
22	Remodeling Project	2003 702	70	10	70		76		22
23	4 Speed Bumps & 16 Curbs Parking Lot	2003 639	64	10	64		64		23
24	Heat Exchanger, Flame Retainer, Heat	2004 1,423	59	10	59		59		24
25	Replace Booster Tank	2004 695	41	7	41		41		25
26	New Flooring in 2 Rooms	2004 2,576	92	7	92		92		26
27	2 F2900 Controllers and Resin	2004 5,880	280	7	280		280		27
28	Rounding		(3)		(3)		(1)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,655,199	\$ 111,805		\$ 111,805		\$ 1,674,130		34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 48,178	\$ 7,561	\$ 7,561			\$ 25,873	71
72	Current Year Purchases	26,459	1,781	1,781			1,781	72
73	Fully Depreciated Assets	516,084	1,571	1,571			516,084	73
74	Corporate Allocation		23	23				74
75	TOTALS	\$ 590,721	\$ 10,936	\$ 10,936	\$		\$ 543,738	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1997 Ford Club Wagon	1990	\$ 3,120	\$	\$		3	\$ 3,120	76
77	Patient Transportation	A/C for Ford Club Wagon	1998	1,040				3	1,040	77
78	Patient Transportation	1999 Dodge Van	1999	22,678	2,268	2,268		5	22,678	78
79	Patient Transportation	Chevrolet Van	2001	20,500	4,100	4,100		5	10,592	79
80	TOTALS			\$ 47,338	\$ 6,368	\$ 6,368	\$		\$ 37,430	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,977,686	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 129,109	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 129,109	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,255,298	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Hydro Therapy Construction	\$ 78,263	92
93			93
94			94
95		\$ 78,263	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,198

Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Transportation	2001 Mercury Sable	\$ 608.19	\$ 7,095	17
18					18
19					19
20					20
21	TOTAL		\$ 608.19	\$ 7,095	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 738	\$	1
2	Cash-Patient Deposits	55,635		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (900)	531,822		3
4	Supply Inventory (priced at Cost)	18,915		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,942		6
7	Other Prepaid Expenses	743		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to / from Corporate	1,416,569		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,029,364	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	684,428		13
14	Buildings, at Historical Cost	3,655,199		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	638,059		16
17	Accumulated Depreciation (book methods)	(2,255,298)		17
18	Deferred Charges	304,876		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,380		21
22	Other Long-Term Assets (specify):	591,167		22
23	Other(specify): Goodwill	343,233		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,965,044	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,994,408	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,635		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,900		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,020		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	33,348		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 336,057	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,510,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,510,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,846,057	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 148,351	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,994,408	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (140,985)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (140,985)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	289,338	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 289,336	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 148,351	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,319,609	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,319,609	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	1,018,811	9
10	Other Government Grants	3,234	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,022,045	23
D. Non-Operating Revenue			
24	Contributions	38,790	24
25	Interest and Other Investment Income***	26,753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,543	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	476,004	28
28a	<u>School Lunch Program</u>	74,824	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 550,828	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,958,025	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	768,557	31
32	Health Care	2,555,749	32
33	General Administration	1,563,990	33
B. Capital Expense			
34	Ownership	569,273	34
C. Ancillary Expense			
35	Special Cost Centers	889,686	35
36	Provider Participation Fee	321,432	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,668,687	40
41	Income before Income Taxes (line 30 minus line 40)**	289,338	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 289,338	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Walter Lawson Children's Home# 0035469Report Period Beginning: 7/1/03Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,080	\$ 69,229	\$ 33.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,269	18,006	391,417	21.74	3
4	Licensed Practical Nurses	18,505	20,741	450,888	21.74	4
5	Nurse Aides & Orderlies	114,514	125,760	1,306,826	10.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,955	2,068	63,339	30.63	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,660	13,505	95,574	7.08	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,928	2,188	38,310	17.51	13
14	Head Cook	7,321	7,964	100,177	12.58	14
15	Cook Helpers/Assistants	1,736	2,193	21,003	9.58	15
16	Dishwashers	1,108	1,174	8,790	7.49	16
17	Maintenance Workers	1,926	2,080	51,734	24.87	17
18	Housekeepers	10,934	12,248	157,311	12.84	18
19	Laundry	6,902	7,705	73,430	9.53	19
20	Administrator	2,032	2,080	100,131	48.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,191	3,431	70,649	20.59	24
25	Vocational Instruction					25
26	Academic Instruction	38,013	41,571	643,554	15.48	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,922	4,351	70,360	16.17	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	10,720	11,667	136,493	11.70	33
34	TOTAL (lines 1 - 33)	255,668	280,812	\$ 3,849,215 *	\$ 13.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	184	\$ 7,340	1.3	35
36	Medical Director	N/A	10,500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	596	40,680	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	11,342	10.3	46
47	<u>Education</u>	216	7,192	43.3	47
48	<u>Other (See Attached)</u>	N/A	27,707		48
49	TOTAL (lines 35 - 48)	996	\$ 104,761		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Walter Lawson Children's Home**# **0035469**Report Period Beginning: **7/1/03**Ending: **6/30/04****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount		
Theo Brandel	Administrator	0	\$ 100,131	Workers' Compensation Insurance	\$ 163,146	IDPH License Fee	\$		
				Unemployment Compensation Insurance	12,574	Advertising: Employee Recruitment			
				FICA Taxes	289,802	Health Care Worker Background Check	620		
				Employee Health Insurance	266,566	(Indicate # of checks performed <u>50</u>)			
				Employee Meals		Illinois Health Care Assoc.	5,022		
				Illinois Municipal Retirement Fund (IMRF)*		MES of Illinois	175		
				Employee Benefits - Other	12,838	ADP Payroll	7,141		
				Corporate Allocation	5,138	Internet	2,353		
						Other Dues	1,874		
						Corporate Allocation	166		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 100,131	TOTAL (agree to Schedule V,	\$ 750,064	TOTAL (agree to Sch. V,	\$ 17,351		
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**	
				to Owners or Employees					
Description			Amount	Description	Line #	Amount	Description	Amount	
Corporate Expense			\$ 147,963	None		\$	Out-of-State Travel	\$ 1,020	
							Non-Allowable Out-of-State Travel	(1,020)	
							In-State Travel	10,830	
							Non-Allowable In-State Travel	(810)	
							Seminar Expense	1,497	
							Corporate Allocation	1,911	
							Entertainment Expense	()	
							(agree to Sch. V,		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 147,963	TOTAL		\$	line 24, col. 8)	\$ 13,428	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Medical Rehabilitation			\$						
Centers, Inc.	Management Fees		405,600						
Thomas Healthcare Consulting	Accounting Fees		3,750						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 409,350						
(If total legal fees exceed \$2500 attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number **Walter Lawson Children's Home**

STATE OF ILLINOIS

0035469

Report Period Beginning:

7/1/03

Ending:

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6/30/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule XIX, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,623 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 321,432
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 74,824
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes (Owned) No (Leased)
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Resnick, Fedder & Silverman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.